REQUEST FOR CMSP DATA AND OTHER INFORMATION/ASSISTANCE

Return to: State of California
Department of Health Services
County Medical Services Program
1800 Third Street, Room 100
P.O. Box 942732
Sacramento, CA 94234-7320

PHONE (916) 322-1478
FAX (916) 323-3350

(Please type or print. Sign and date the agreement below.)

TYPES OF DATA, INFORMATION, AND ASSISTANCE AVAILABLE

1. File Documentation, Record Layouts, Data Dictionaries
2. Data Extraction and/or File Transfer
3. File Access and/or Programming Support
4. CMSP Program Eligibility, Scope of Benefits, Providers
5. CMSP Program Expenditures, Month of Payment Reports
6. Custom Data Analysis, Interpretation, or Presentation
7. Geographic Information Systems Mapping
8. Consultation and Technical Assistance
9. Review and Evaluation of Research Proposal—Committee for the Protection of Human Subjects
10. Presentations, Conferences, and Workshops
11. Communications with CMSP Governing Board—CMSP County Representatives

Requester name	Requester title
Organization	

Mailing address (number and street)	City	State	ZIP code

Telephone number (include area code)	FAX number (include area code)	Date of request	Desired completion date
( ) -	( ) -		
(Please allow ten working days for completion.)		Electronic mail address	

Detailed Description of CMSP Data or Information/Assistance Requested

What question(s) do you need answered?

Who is your audience?

What type of format do you need? ☐ Paper ☐ Electronic Please specify media (diskette, Zip Disk, cartridge tape, etc.):

Provisions of this Agreement

1. Protection of the confidentiality of the CMSP beneficiary data is a foremost consideration. Table or text derived from these data should not contain cells with counts of fewer than ten (10) events. Protect all computer files with appropriate confidentiality safeguards. Refer any questions regarding confidentiality of CMSP data to the Chief, county Medical Services Program.
2. All publications using the information provided must acknowledge the California Department of Health Services (DHS), Office of County Health Services, County Medical Services Program, as the original source.
3. If you use the information, please issue a disclaimer crediting any analyses, interpretation, or conclusions reached to the authors and not to the DHS County Medical Services Program.
4. Parties must assure that technical descriptions of the data are consistent with those provided by the DHS County Medical Services Program.
5. Use the data provided only for the purposes stated in the data request form, unless you obtain prior written approval.
6. Do not release any of the data provided to any third party.
7. Computer files with CMSP data shall be returned upon completion of all analyses pertaining to this request.
8. Send a copy of any material derived from the information requested to the DHS County Medical Services Program.
9. Consultations with DHS County Medical Services Program staff to discuss uses and limitations of the data are encouraged.

By the signature below, I agree to abide by the above conditions.

Signature	Type or print name of person signing	Date

For office use only: Data request ID number: _____

Additional information for requesters: Epidemiologic information and assistance is available by mail, fax, phone, or in person.

FOR CMSP OFFICE USE ONLY

Request ID number	Request received by	Date

Request approved by manager	Date

Assigned to	Date

Comments

Work reviewed by	Date

Amount of time spent on request	Date request delivered

Request product: ☐ Paper ☐ Diskette ☐ Other _____

Mode of delivery: ☐ Mailed ☐ Faxed ☐ Other _____

If data were provided, date(s) followup contact made to inquire about data destruction:

Date requester indicated data were destroyed	Comments

For office use only: Data request ID number: _____